GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUDIT OF THE DEPARTMENT OF MENTAL HEALTH'S PATIENT ACCOUNTS

CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

OIG No. 01-1-06RM(a) **June 13, 2002**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

June 13, 2002

Martha B. Knisley
Director
Department of Mental Health
77 P Street, N.E., 4th Floor
Washington, D.C. 20002

Dear Ms. Knisley:

Enclosed is our final report summarizing the results of the Office of the Inspector General (OIG) Audit of the Department of Mental Health's (DMH) Patient Accounts (OIG No. 01-1-06RM(a)). The audit was requested by the Office of the Mayor and the newly appointed Director of the Department of Mental Health (DMH).

As a result of our audit, we directed 14 recommendations to DMH for necessary action to improve controls over patient accounts. We want to acknowledge that DMH has reacted positively to our identification of issues and has taken action to address our recommendations.

The DMH comments to our draft report are incorporated where appropriate. The full text of the DMH response is included as Exhibit A.

We appreciate the cooperation and courtesies extended to our staff during the audit. If you have questions, please call me or William J. DiVello, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

Charles C. Maddox, Esq.
Inspector General

CCM/ws

Enclosure

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AUDIT OF THE DEPARTMENT OF MENTAL HEALTH'S PATIENT ACCOUNTS

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OVERVIEW

The District of Columbia Office of the Inspector General (OIG) has completed an audit of the Department of Mental Health's (Department) patient accounts. This is the first of a series of reports to address various functions associated with the delivery of mental health services by the Department. The audit was requested by the Office of the Mayor and the newly appointed Director of the Department of Mental Health (DMH). The audit was performed to determine the adequacy of the Department's policies and procedures for managing patient accounts and to evaluate the Department's fiduciary responsibilities when it acts in the capacity of a representative payee for the patients. We also assessed the effectiveness of the Department's internal controls over the receipt and disbursement of patient funds.

CONCLUSIONS

The Department's patient accounts were not effectively or efficiently managed. An analysis of approximately 3,000 accounts valued at about $3.7 million and maintained by the Department disclosed:

- Approximately 600 accounts totaling over $1 million had accumulated, for possibly as long as 30 years, for deceased patients because procedures had not been established to notify relatives of funds remaining in these accounts.

- Limited amounts of funds (usually burial funds) have been disbursed to relatives of deceased patients during this 30-year period.

- About 1,000 accounts had balances of less than $10, many with less than $1, and therefore, should be closed out.

- The Department continued to maintain approximately 900 open accounts totaling over $250,000 for patients who were discharged.

- The Department maintained a significant number of accounts for patients who were cared for and resided in contractor operated residential care facilities. Elimination of these accounts can significantly reduce time-consuming workload duties.

Additionally, Department case managers did not always fulfill their fiduciary responsibilities as representative payees for the patients. We found instances where patients, not competent to handle their own money, were provided large sums of cash that ultimately were used by patients to buy drugs and alcohol. In some cases, patients were subsequently arrested for conduct that resulted from drug and alcohol abuse. There were also payments of District funds made to ineligible patients.

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Finally, we noted that the Department did not implement prior audit recommendations because the system for tracking recommendations was not effective. The recommendations were designed to improve patient account management.

CORRECTIVE ACTIONS

We addressed recommendations to the DMH that represent actions considered necessary to address the concerns described above. The recommendations, in part, centered on:

- Strengthening policies and procedures, in accordance with D.C. probate laws and regulations, for handling accounts of deceased patients and ensuring that funds in these accounts are disbursed to their relatives or next of kin.

- Developing a formalized process to evaluate and re-evaluate the need for a patient to be assigned a representative payee, to include information about the identity of who is the most appropriate person/agency to be the representative payee.

- Establishing policies and procedures for maintaining accounts with minimum balances and for eliminating accounts that do not meet those criteria.

- Establishing policies and procedures to ensure that supporting documentation is obtained for all funds disbursed to patients and that all disbursements are authorized for bona-fide daily living expenses.

- Establishing policies and procedures to ensure that patient benefits are reduced when a change of address occurs (i.e., release from a hospital, imprisonment, or a commitment by court order because of mental impairment, etc.) and ensuring that a change of address is reported to the Social Security Administration.

- Developing a formal tracking system that addresses individual recommendations and ensures that all of the recommendations contained in this and prior audits are implemented.

- Obtaining the services of an independent public accounting firm to conduct an immediate audit of the patient accounts to reconcile account balances in the Patient Accounts System.

On May 29, 2002, DMH provided a formal response to the recommendations in the draft report. Generally DMH officials concurred with the report, its conclusions and its recommendations. DMH's response included actions taken, planned, and target dates for completion of planned actions to correct noted deficiencies. We consider DMH's comments

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and actions taken to be responsive to the audit recommendations. The complete text of DOH's response is included as Exhibit A.

OTHER MATTERS OF INTEREST

We noted several positive developments which we believe can lay the groundwork for corrective action. In 2000, a private contractor conducted a management audit of the Commission on Mental Health Services. A wide range of deficiencies related to the patient accounts management functions were major findings of that review. It was the view of the new Director of DMH as she assumed her new responsibilities in May 2001 that the Receiver's office had not given adequate attention to the section of the PWC audit on patient accounts. Additionally, the Director had begun planning to remediate problems with patient accounts and also to shift the responsibility of representative payee from DMH to an independent third party. The Director also had begun to set new policies and requirements for contract providers and residential providers so that a more accountable, non-conflictual system could be established.

In order to begin to address these problems, the Director sought out the services of an expert in client benefits. The identified contractor had overseen reform of the representative payee process in Ohio a number of years ago. The reforms adopted there have been adopted in many states and have been promoted by the Social Security Administration across the country. The contractor began in December of 2001 and began immediately to assist DMH. The contractor was engaged fulltime for a period of three months and remains available on a consultative basis.

DMH set up a representative payee Workgroup in December 2001. The workgroup met and began implementation of corrective actions in December 2001 to address the significant deficiencies in the current Patient Accounts Management System. Since the actions of workgroup are still a work in progress, we have been advised that these findings will be reviewed carefully and integrated into DMH's overall corrective action plan.

INTRODUCTION

BACKGROUND

The overall mission of the Department is to develop, support, and monitor an effective and integrated community based system of services for persons with identifiable mental health needs. The Department's fiscal year 2001 budget was $204 million and for fiscal year 2002, the budget is estimated at $227 million. The Department achieves its mission by providing workforce development programs and services through five control centers:

- Mental Health Administration - Provides executive management policy direction, strategic and financial planning, and public relations and resource management over the operation of the Department in meeting the mandates of the court and improving the delivery of mental health services.

- Community Programs - Administers a comprehensive system of care that promotes recovery and maximum independence in safe, supportive community settings. The system is comprised of a full range of community-based clinical and support services initiated through the development of new initiatives.

- St. Elizabeth Hospital - Provides a wide range of services to the acute care program. Services include clinical assessment, diagnosis, psychiatric stabilization, and referrals to appropriate aftercare services.

- Forensic Services - Provides training for forensic staff and advance research initiatives to constantly improve evaluation and treatment methodologies. It also collaborates with the District government, the Courts, and the criminal justice agencies on pre- and post-booking jail diversion alternatives.

- Child and Youth Services - Provides inpatient and outpatient treatment services for at-risk children and children with emotional disorders. The division coordinates treatment by building on the strength of child/family relationships. It also responds to individual cultural differences and incorporates special needs of each family into treatment plans. In addition, the division provides other services, including school-based treatment and psychotherapy day education.

EXECUTIVE DIGEST

OBJECTIVES, SCOPE, AND METHODOLOGY

The overall objectives of the audit are to determine whether the Department: (1) managed and used resources in an efficient, effective, and economical manner; (2) administered funds in compliance with applicable laws, regulation, policies and procedures; and (3) implemented internal controls to prevent or detect material errors and irregularities.

Our specific objectives in this audit were to determine whether the Department had implemented the necessary controls needed to effectively manage patient accounts and to evaluate the Department's procedures and controls used to comply with the fiduciary duties and responsibilities of representative payees for the patients. This audit was performed at the request of the Office of the Mayor and the newly appointed Director of the Department of Mental Health.

In accomplishing our objectives, we interviewed the Department's management and administrative staff to gain a general understanding and an overview of the policies and procedures for controlling patient accounts. We also downloaded and analyzed the Patient accounts System (PAS) database for patient accounts and sampled supporting documentation for disbursements.

In addition, we followed up on recommendations made to the Department in prior audit reports on its management of patient accounts to ascertain whether corrective management had taken action.

The audit primarily covered transactions for the period January 1, 2000, to September 30, 2001, and in some cases, when necessary, we reviewed transactions outside of this period. The audit was conducted in accordance with generally accepted government auditing standards and included such tests as we considered necessary under the circumstances.

FINDINGS AND RECOMMENDATIONS

FINDING 1: MANAGEMENT OF PATIENT ACCOUNTS

SYNOPSIS

The Department did not maintain effective fiduciary management of patient accounts. The Department maintained: (1) about 600 accounts for deceased patients, valued in excess of $1 million, that had accumulated for possibly as long as 30 years; (2) about 1,000 accounts with balances of less than ten dollars; (3) approximately 900 accounts for patients discharged; and (4) a significant number of accounts for patients who resided in contractor-operated community residential facilities (CRFs). The excessive number of accounts was maintained because the Department had not established effective policies or implemented procedures for notifying next of kin, distributing the funds of deceased patients, and reviewing the need for patient accounts. As a result, relatives of deceased patients were denied access to deceased patients funds and access to other patient funds was delayed. In addition, maintaining a large number of accounts places an unnecessary administrative burden on management and exposes the Department to an increased risk of fraud and abuse.

DISCUSSION

The Department's PAS provides management information on account balances, patient names, locations, and dates for admission, discharge, and death for all patient accounts. The PAS also provides routine reports showing balances and detailed information on account transactions.

As part of our audit of patients accounts, we downloaded and analyzed data from the PAS database. The accounts were categorized by the type of patient: deceased, discharged, and other than discharged or deceased. The balances in these accounts as of September 30, 2001, are shown in the following table:

FINDINGS AND RECOMMENDATIONS

TABLE -- SUMMARY OF PATIENT ACCOUNTS

Patient Type	Number of Accounts	Dollars
Deceased	595	$1,082,212
Discharged	886	261,656
Other Than Discharged or Deceased	1,499	2,386,202
Total	**2,980**	**$3,730,070**

Further detailed discussion of the patients accounts follows.

Deceased Patient Accounts. Written procedures for the disposition of deceased patient funds and notification of relatives are limited and contained in two Department policy documents:

- Policy 50000.381.1A, dated July17, 1991, requires the physician on duty to notify the relatives of the patient's death and pending funeral arrangements.

- Policy 50000.532.1.10 B, dated September 8, 1988, states the following: "Deceased Patients/Clients. (1) A deceased patient's/client's funds are frozen at the time of death. Disbursements will be made in accordance with probate procedures."

The absence of definitive guidance on the disposition of deceased patient funds was readily apparent when analyzing hospital resident death rates and the number of deceased patient accounts. The Department's annual statistical report indicated that the hospital experienced 18 resident deaths for fiscal year 2000. As the above table shows, there are about 600 deceased patient accounts, which in total are valued in excess of $1 million dollars. Therefore, based strictly on the hospital death rate for fiscal year 2000 and the approximate 600 deceased patient accounts, we estimate the above deceased patient accounts were likely to have accumulated over the past 33 years (595 accounts divided by an approximate average of 18 deaths per year).

Our analysis of the accounts indicates that the average balance in the patient accounts was in excess of $1,800. Further, we noted that more than 200 accounts have balances in excess of $1,000, 12 accounts have balances in excess of $10,000, and one balance was in excess of $30,000.

We reviewed the records of 15 deceased patients to evaluate actions taken by the Department to notify relatives about the funds remaining in their accounts. The Department provided us 12 patient files (DMH personnel could not locate the files for 3 patients) for our review to

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determine if the names of the patient's relatives were readily available and whether the relatives had been notified of the deceased patients remaining funds.

We noted that the names and addresses of the next of kin were readily available for eight of the patients. We believe that a more detailed review may have provided additional names and addresses. However, we did not find documentation in any of the 12 records to indicate that Department personnel had notified relatives of the deceased patients about the remaining funds in their accounts. Further, we assessed the age of these accounts and noted that one patient had died 15 years prior, and 2 had died 12 years prior.

We expanded our test to further assess the age of these accounts. We obtained the social security numbers of 109 additional deceased patients. We then queried Ancestry.com's Social Security Death Index (SSDI) database to obtain the deceased patient's date of death. The SSDI did not have information on 39 individuals (these individuals may have died prior to 1980 and were not entered in the SSDI). The expanded SSDI sample of 70 individuals identified 2 individuals who had died 17 years ago. We concluded these accounts have existed for as long as at least 17 years and possibly longer.

Department personnel informed us that it was Department policy to notify relatives of the patient's death, the pending funeral arrangements, and whether the deceased patient had burial funds. However, burial funds represent only a portion of a patient's fund. For example, if a patient had a fund balance of $7,000, ($5,500 in the regular account and $1,500 in the burial fund) relatives were only notified of the $1,500 burial fund.

We contacted the relatives of two patients in our sample to determine if they had been notified of deceased patient funds as discussed below:

- We contacted the sister of a patient who died November 4, 1998, who told us that the only notification she had received was a notification regarding the death of her brother and the pending funeral arrangements. The sister had not been advised, and was unaware, that the brother had over $10,000 in patient funds in St. Elizabeth's bank account.

- We contacted another relative of a deceased patient. This deceased patient had funds remaining in his account in excess $10,000 on September 30, 2001. We noted that the funds had been returned, subsequent to our sample, to the deceased's niece in December 2001. However, the Department did not notify the niece that the uncle had a patient account with remaining funds. The niece handled the burial arrangements and incurred funeral expenses in excess of $6,000. The niece advised us that in going through the uncle's paper work from St. Elizabeth's Hospital, she determined that the uncle had a patient account at the hospital. After the funeral, she contacted representatives from St. Elizabeth's

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Hospital and requested reimbursement for the funeral expenses she had incurred and for any remaining funds that she might be entitled to.

The niece indicated she made repeated requests for nearly a year to obtain information from St. Elizabeth's Hospital on the uncle's remaining patient account balance. The request went unanswered and the niece resorted to calling the Office of the Mayor for assistance. The niece indicated the whole experience was "miserable," and that funds were returned only through the intervention of the Office of the Mayor.

During an exit conference with DMH officials, they informed us that in October 2001, St. Elizabeth's began reviewing the accounts of all deceased patients for the purpose of identifying and clearing accounts of deceased patients that were being maintained in the Patient Accounts System. Additionally, DMH officials stated that this condition had already been identified in a report issued to DMH by an outside contractor in April of 2000. It was their position that our audit confirmed that this condition continued to exist. DMH personnel stated that they will aggressively continue to identify those accounts and attempt to contact relatives of the deceased patients.

Our analysis of the report prepared by the contractor found that it did identify that "there are a large number of accounts (i.e., "dormant accounts") with balances for consumers that are no longer associated with the CMHS (i.e., "discharged patients"). However, that report made no mention and did not detail any information on "deceased" patient accounts. Additionally, our auditors were not informed that the contractor who prepared the report had discussed this matter with DMH officials in any more detail, hence we believed this to be a new issue. Regardless of who surfaced this issue, we recognize DMH's acknowledgement of the problem and believe that they have begun and will continue to make progress in correcting the deficiency.

The process for notifying relatives about a deceased patient's account balances has not worked and has led to a possible 30-year accumulation of funds that should have long ago been distributed in accordance with District of Columbia probate procedures. The Department has not effectively carried out this final but important fiduciary responsibility. As noted in the recommendation section at the end of this finding, we consider this to remain an open item.

Discharged Patients. Procedures for closing accounts for discharged patients are contained in Policy 50000.532.1, dated September 8, 1988, which states:

- 10. a. Discharged Patients/Clients Form 193, Discharge or Death Report will notify the Patient's Accounts Unit of the discharge and discharge address. The program staff must ensure that the address given on Form 193 is current, complete and legible. If the patient/client is payee of the funds, a check will be processed immediately.

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- If the Department is the payee of public benefit checks, a new payee must be established. The new payee must file to be payee. If a new payee is not established, the funds are required to be returned to the funding source.

To evaluate the Department's implementation of this policy, we randomly selected 3 of the 886 accounts (shown in the table) for discharged patients. We found that the patients had in fact been discharged, but the Department was still the representative payee and the patient's funds were not returned. In addition to confirming the accuracy of the 886 patient discharge records, we supplemented our review by obtaining and analyzing two special management reports: Report Number PAS 13M titled Management Summary of Discharged Patients with Active Accounts in PAS-All Payees for CMHS Commissioner, and PAS 12 M titled Report Management Summary of Discharged Patients with Active Accounts in PAS-All Payees Excl CMHS Commissioner.

Our review of these 2 reports indicated more than 800 accounts remained for patients that had been discharged more than 180 days, some for more than 10 years. Department personnel told us they were aware of the large number of accounts but did not have a sufficient number of personnel to properly process the accounts. The net effect of this inaction is that a large sum of money ($261,656) is left in inactive accounts when it should be expeditiously paid to the discharged patients.

DMH officials stated that the Community Services Agency (CSA) is now independently responsible for locating discharged consumers and ensuring that funds are returned to the appropriate party and has established a process. At the time of discharge, the Hospital Associate Director for Finance and Information Systems coordinates identification of those accounts that need to be closed with the Patient Accounts Unit at DMH.

Accounts for Other Than Discharged or Deceased Patients. The Department has not taken the action needed to transfer representative payee duties and responsibilities or to eliminate accounts with minimum balances.

Some individuals require assistance in money management, as well as guidance in handling daily activities. Representative payees are established for these individuals. The Department is the representative payee on approximately 3,000 accounts valued at about $3.7 million. There are two different kinds of representative payees.

- **Individual.** Someone that a beneficiary lives with or a family member or friend who does not live with the beneficiary. It can also be a lawyer, a legal guardian, or a volunteer for a government or non-profit agency.

- **Organizational Payee.** This category includes social service agencies, an official of a government agency, or financial organizations.

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As part of our audit we reviewed the files for 34 patient accounts classified as "Other Than Discharged or Deceased Patients." We found that 20 patients, more than half of our sample, were not residing at St. Elizabeth's Hospital. The 20 patients were residing in contractor operated Community Residential Facilities (CRF). CRFs are non-profit agencies and also qualify, in most cases, to serve as patients' representative payees.

We expanded our sample and requested a private organization that operates several CRFs to provide the names of Department patients that were in their care. In comparing the list of CRF patients to St. Elizabeth's Hospital patient accounts, we noted St. Elizabeth's Hospital had patient accounts for 91 patients that were in contractor operated CRFs. Based on our sample results, we estimate that 750, or about half of the patient accounts for Other Than Discharged or Deceased Patients, should be maintained by the CRF.

Elimination of these accounts can significantly reduce time-consuming workload duties and the Department's requirements while acting in the capacity of a representative payee. Those duties require the efforts of qualifying the patient for Social Security benefits, monitoring the continued eligibility of those benefits, providing financial oversight of client funds, and filing other periodic reports with the Social Security Administration.

Accounts Maintained With Low Balances.

The Department maintained over 1,000 accounts that have balances of less than $10. We downloaded the PAS database and determined that the Department was maintaining records on over 1,000 accounts that had balances of less than $10, which in aggregate totaled less than $1,700. Further analysis of these same accounts indicated there were over 900 accounts with a balance of less than $5, with an aggregate value of about $700; and more than 700 accounts with a balance of less than $1 with a total value of about $200.

We queried area banks on the minimum balance needed to establish an account. We were informed normal commercial banking procedures require at least minimum balances of $50 to $100 before the bank will allow customers to maintin an account without charging the account a monthly fee or paying interest on the account. It was not cost effective for them to maintain accounts below those balances.

However, the Department has not adopted these commercial banking procedures and is unnecessarily maintaining more accounts than it can adequately manage. More than a third of the accounts have minimal balances, and thus should either be disbursed (if the account is determined to be active) or eliminated (if the account is determined to be inactive) in accordance with District laws for unclaimed property. Printouts of patient trial balances (the PAS 06 Report) are sent monthly to case managers who have the responsibility of reviewing and managing patient accounts. In our opinion, the monthly distribution of over 1,000 accounts with minimum balances is inefficient, time consuming and requires unnecessary case management time to review these reports.

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We were informed at the exit conference that St. Elizabeths now has a minimum balance policy for inpatients. However, DMH officials stated that establishing minimum balance criteria is not a useful monitoring tool for community-based consumers served by the CSA and other contract providers since many consumers require all of their monthly income to meet their basic needs. Therefore, their accounts will always have very low balances.

RECOMMENDATION 1

We recommended that the Director, DMH strengthen policies and implement procedures, in accordance with D.C. probate laws and regulations, for handling accounts of deceased patients.

DMH RESPONSE

DMH officials stated in its response that St. Elizabeth's and the CSA are rewriting internal policies to address a more expedient way to release funds following a patient's death. A review of D.C. Probate regulations and a legal opinion from General Counsel is needed prior to finalizing our policy.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 2

We recommended that the Director, DMH review all files of deceased patients, initiate actions to ensure relatives of deceased patients are notified of funds that remain in their accounts, and disburse the funds in accordance with probate or other legal requirements.

DMH RESPONSE

DMH officials stated in its response that the Associate Director for Finance and Information Systems of St. Elizabeth's and the Chief Financial Officer of the CSA will continue to coordinate the review with the DMH Patient Accounts Unit to identify all deceased patients' funds. Funds will continue to be disbursed in accordance with probate and other legal requirements.

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OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 3

We recommended that the Director, DMH develop and implement procedures to ensure discharged patients are provided funds at time of discharge.

DMH RESPONSE

DMH officials stated in its response that as part of the ongoing policy review, St. Elizabeth's is developing policies that allow inpatients to withdraw all funds at time of discharge if they are medically competent. Procedures coordinating Office of Patient Financial and Legal Affairs (OPFLA) with other financial systems are being developed. The policies and procedures address different needs of competent and incompetent patients and allow all medically competent patients to receive the entire amount in their account on the day of discharge. In cases where St. Elizabeth's is the representative payee for incompetent patients, procedures will coordinate the transfer of funds with the OPFLA prior to the patient's discharge.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 4

We recommended that the Director, DMH locate discharged patients and disburse funds to the identified discharged individuals.

DMH RESPONSE

DMH officials stated in its response that the Associate Director for Finance and Information Systems at St. Elizabeth's will continue to coordinate identification of those accounts that need to be closed with the Patient accounts Unit at DMH. Staff at the Hospital will complete Form 267 on all discharged patients for whom an address can be found. Additionally, accounts for patients who cannot be located will be referred back to the Finance Department for processing in accordance with Federal and DC regulations regarding unclaimed funds. See the full text of DMH's response for details.

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OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 5

We recommended that the Director, DMH direct community residential facilities to establish patient accounts for all of the Department patients residing in their facilities. Transfer representative payee responsibilities to contractor operated community residential facilities, where appropriate.

DMH RESPONSE

DMH officials stated in its response that DMH will meet the intent of this recommendation by making the independent agency chosen by the RFP process the representative payee for all community-based consumers. It has been and will continue to be the policy of DMH to discourage the use of community residential facilities as the representative payee because of the inherent conflict of interest associated with being a provider of service to a consumer while at the same time being responsible for the management of that consumer's funds.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 6

We recommended that the Director, DMH establish policies and implement procedures for maintaining accounts with minimum balances and eliminate those accounts that do not meet those criteria.

DMH RESPONSE

DMH officials stated in its response that St. Elizabeth's has established a policy that requires a minimum account balance of $25.00 and closes accounts that fall below that amount for more than 90 days. Social workers monitor the accounts using the monthly Patient accounts System reports.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

FINDINGS AND RECOMMENDATIONS

FINDING 2: CASE MANAGEMENT OF PATIENT FUNDS

SYNOPSIS

Case managers were not ensuring patient funds were expended solely for residential care and personal needs, and were not conducting effective case management reviews. On several occasions case managers provided cash to patients with known drug and alcohol abuse problems, where the patients were subsequently arrested for conduct that resulted from drug and alcohol abuse. In addition, eligibility criteria for patient benefits had not been effectively evaluated and utilized. Further, payments of Social Security Supplemental Income (SSI) and District Funded State Optional Payments were made to patients who were ineligible to receive those benefits. Patients also were not always provided minimum funds for personal expenses established by the Social Security Administration, and patient burial funds were not always established. Consequently, patient funds were exposed to unauthorized or unintended use.

DISCUSSION

The Social Security Administration (SSA) administers an SSI program that provides income and security for aged, blind, or disabled persons and their dependents or survivors. In order to qualify for SSI, the individual cannot have more than $2,000 in resources (home ownership and car are not counted). SSA provides a basic monthly SSI payment of $531 and the District provides a monthly State Optional Payment of $307.

As a representative payee, the Department's case managers receive and manage these payments on behalf of the patients. Case managers are responsible for ensuring SSI payments are used only for current basic needs, such as food, clothing, shelter, etc., and are required to report changes in living arrangements and changes in patients' addresses to the Social Security Administration. Representative payees may be held liable if they do not report changes that could affect the recipients SSI payment amount and the recipient is overpaid.

Documenting and Managing Expenditures from Patient Accounts. We randomly selected 37 patient accounts to evaluate case managers' fiduciary role as the patients' representative payee (the records for 2 patients could not be located). We noted that regional health center managers have adopted different policies for ensuring patients are provided funds only for residential care and personal needs. Some of the managers require case managers to document purchases for the patients (case managers duties include making purchases for patients). Further, some managers restrict cash advances to patients to $50 dollars while others allow cash advances of up to $300.

FINDINGS AND RECOMMENDATIONS

The effects of providing patients with large cash advances were immediately evident during our review. Our examination of some medical records for the 37 accounts identified 5 instances where case managers provided cash payments from $200 to $300 dollars to patients identified as active drug and alcohol abusers. On three separate occasions, documentation showed that case managers provided a known alcohol and drug abuser with cash that was used to purchase drugs and alcohol:

- On July 7, 2000, the patient admitted to the case manager that he had used cocaine and was drinking alcohol 4 days prior. That same day, the case manager gave the patient $100 in cash. He missed his appointment with the case manager the following week because he was arrested for alcohol abuse.

- Three months later on October 26, 2000, the same patient was given $300 in cash. He was arrested the following week for possession of illegal drugs and was jailed for 2 months.

- On June 27, 2001, case managers initiated a voucher for "personal spending" for the patient. On July 3, 2001, the patient's accounting records indicated he received $300 in cash. On July 5, 2001, the patient's medical records indicated he was arrested for "drinking alcohol in public."

In reviewing the records of another patient, we noted the following:

- On July 26, 2000, the patient declined to take a random drug test because he admitted to using crack cocaine on July 23, 2000. Two weeks prior, the case manager gave the patient $300 for "food and personal spending" without obtaining a receipt.

- In October 2000, this same patient was given $300 in cash. That same month, we noted a letter in the patient's medical records from the patient's counselor that the $300 given the patient, by the Department's case manager, was used to buy crack cocaine.

- We noted a third patient was given a cash payment of $400 which was subsequently used to purchase drugs according to the case manager.

We believe that providing large sums of cash to patients diagnosed as drug or alcohol abusers raises serious questions as to the efficacy of the patients' therapeutic program administered by the Department. In addition, providing cash without adequate record keeping controls may contribute to an undetected theft of funds (This matter will be discussed further in Finding 3.)

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The records for another patient in our sample contained the following note, "Client unable to manage money wisely-sometimes gives large sums of money away." Yet the patient had been given cash advances ranging from $100 to $300 on 30 different occasions, which totaled $7,250 in a 12-month period.

In reviewing another case, the patient's medical records contained an entry dated November 1, 2001, stating, "Last treated on 3-19-01, and has not been in since." However, his patient account was charged "personal expenses" of $200 for the months of April through September 2001, totaling $1,200. There was no documentation for these expenditures.

As a final example, we reviewed the PAS transaction report for a patient who received personal spending funds of $1,250 in a 2-month period, which exceeded Social Security guidelines of $30 per month. We were unable to locate the patient's medical records but noted from the patient's account records that she was jailed for a 3-month period on November 11, 2000. Her PAS 22 report indicated that she received $225 the week prior to her arrest and $250 while incarcerated.

DMH officials stated that St. Elizabeths Hospital is implementing enhanced procedures to correct mistakes and ensure that the documentation is obtained for all funds given to inpatients. The procedures include provisions for additional verification of receipts for expenditures. Additionally, the position descriptions for social workers are being amended to reflect the new requirements of the procedure.

Social Security Spending Guidelines. Social Security Administration regulations covering SSI recipients restrict the use of SSI funds to housing, food, and personal needs. To ensure only authorized items are purchased, a representative payee must complete a periodic review of non-medical eligibility factors (i.e., income, resources, and living arrangements) to ensure that the SSI beneficiary is still eligible for and receiving the correct payment. SSI benefits to beneficiaries (patients) are discontinued if the beneficiary's resources exceed $2,000.

Our review of patient disbursements indicated case mangers were not always following these guidelines. For example, one of the individuals in our sample purchased, with the caseworker's approval, a 32-inch color TV for $3,100, which is the equivalent of 6 months SS income. Purchases of this nature are not authorized and will disqualify the patient from continued SSI.

At the exit conference, DMH officials agreed that improvements in this area were needed. As such, special guidance for physicians and other treatment team members was developed to use in completing Form SSA-787. Additionally, training of CSA staff began in April 2002 and will be completed by the end of June 2002.

Minimum Spending Guidelines. Guidelines provided by Social Security suggest that, if the beneficiary lives in an institution or other care facility, the representative's payee should

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spend at least $360 annually for the beneficiary's personal needs. In our sample of 35 cases, we noted 10 instances where case managers did not meet these guidelines. In each of these ten cases, the beneficiaries were not provided with any spending money for personal needs.

Managing Beneficiary's Changes in Address. The movement of a beneficiary (patient) to or from a hospital, nursing home, or other institutions is required to be reported to the SSA. Patients imprisoned for a crime that carries a sentence of over 1 month and those committed to an institution by court order for a crime committed (because of mental impairment) are also required to be reported because the patients' eligibility for benefits is curtailed. Those individual benefits are in the form of monthly SSI benefits of $530 ($796 for couples) and supplemental District State Optional Payments of $307 per month. The total of these 2 payments, $838 per month, is authorized to eligible beneficiaries living in approved CRFs.

Our sample of 35 patients identified a high percentage of incorrect payments. Seventeen patient changes of address involved incorrect SSI or State Optional Payments (i.e., 48 percent of our sample) and had not been timely reported to the Social Security Administration by case managers. Overpayments in SSI or State Optional Payments resulted.

- **Five Overpayments in State Optional Payments**

Included in our sample were two overpayments of the State Optional Payments to patients who were not living in approved CRFs. In one instance, the patient was living in a personal residence and in another the resident had moved to an independent living facility. The changes in addresses were not reported, and they were over paid a total of $10,471.

Two additional patients were admitted to St. Elizabeth's Forensic Inpatient Services Division under court order and remained there for periods ranging from 4 to 9 months. They were overpaid a total $4,887 in State Optional Payments.

An additional patient was admitted to the St. Elizabeth's Hospital Long Term Care Ward for the period April 1, 2001, to December 31, 2001. His change of address was not reported and he continued to receive State Optional Payments of $307 per month, or $3,684 for the entire year.

- **Overpayments in SSI**

Two of the five individuals noted above were committed to the forensics services and were overpaid in SSI funds, as was an additional individual who was admitted to the Saint Elizabeth's continuing care division. That individual received only the SSI benefit and did not receive the State Optional payment. Again, all of these overpayments were attributed to caseworkers not reporting a change of address, which affected the patients' eligibility for these payments.

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- **Potential SSI Overpayments.**

Eleven of the patients in our sample that had patient accounts maintained by St. Elizabeth's Hospital resided in CRFs and received monthly SSI payments but were not charged rent. The patient account balances for each of these ten patients exceeded $2,000 because the CRF's had not billed the patient accounts for rent. Patients living in CRF's are charged an average monthly rent of $767. Social Security Administration funds, not District funds, are designed to pay a patient's CRF rental expenses to reduce the costs of care to municipal agencies. However, by not charging patient accounts for rent, District funds, rather than SSI funds, are being used**.** The potential overpayments amounted to $16,047.

Representative payees are required to report patients' income and total resources periodically, and if those resources (other than home or car) exceed $2,000, the SSI payments are discontinued. For these eleven individuals above, unbilled CRF rental expenses can result in excess patient funds being returned to the funding source and the charging of District funds to cover rental expense. The CRF representative for one of these patients informed the auditor that he had not billed the patient's account because he was unaware of the patient's balance.

Establishing Burial Fund Accounts. Representative payees are also responsible for ensuring that allowable resources do not exceed $2,000 to prevent a denial of future benefits. Burial funds are not counted against the beneficiary's $2,000 resource limitation and the Social Security Administration endorses the establishment of beneficiary burial funds as a method of retaining beneficiary resources. Our review of the patient account balances as of September 30, 2001, identified 98 SSI accounts with balances in excess of $2,000. However, the Department had established burial accounts for only 13 patient accounts, (i.e. 13 percent).

We were informed at the exit conference that the Patient Accounts Unit is now distributing individual listings of account balances on a regular basis, that are sent to social workers for review prior to filing. A review is completed of patients for whom the hospital is representative payee, but no burial fund is in place. Treatment teams discuss with the patient the advisability of establishing such a fund. Requirements established by the Social Security Administration for representative payees will be followed in all cases.

RECOMMENDATION 7

We recommended that the Director, DMH establish internal controls and procedures to ensure that supporting documentation is obtained for all funds disbursed to patients and that all disbursements are authorized for bona fide daily-living expenses.

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DMH RESPONSE

DMH officials stated in its response that the independent representative payee agency will be required to have an established set of internal controls and procedures that meet all SSA requirements. St. Elizabeth's Hospital is implementing enhanced procedures to correct mistakes and ensure that the documentation is obtained for all funds given to inpatients. See the full text of DMHs response for details.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 8

We recommended that the Director, DMH develop and implement a formalized process to evaluate and revaluate the need for a patient to be assigned a representative payee.

DMH RESPONSE

DMH officials stated in its response that for inpatients at St. Elizabeth's, a process already exists to evaluate whether or not a patient needed a representative payee. Work in this area is ongoing and improvements in this area should be recognized. Additionally, CSA treatment teams have begun the process of incorporating a financial management component in every treatment plan.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 9

We recommended that the Director, DMH develop procedures for ensuring beneficiary entitlements are reduced when changes of addresses occur, to meet Social Security Administration guidelines for dispensing minimum payments to patients, and to ensure that changes of address are reported to the Social Security Administration where release from a hospital, imprisonment, or commitment by court order because of mental impairment occurs.

FINDINGS AND RECOMMENDATIONS

DMH RESPONSE

DMH officials stated in its response that St. Elizabeth will continue to follow its existing procedure of notifying Social Security Administration when a patient is admitted and discharged. Additionally, the CSA has completed Social Security Disability Income training for all case managers. Training in representative payee duties and responsibilities has been planned. The CSA will coordinate the installation of its management information system to interface with the DMH contract management system.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 10

We recommended that the Director, DMH develop procedures to ensure that patient accounts are charged rent and that District funds are not used to pay for this expense until responsibility for a patient account transfers to the Community Residential Facility.

DMH RESPONSE

DMH officials stated in its response that a two-cycle rent payment system will be established. Job descriptions will be amended to reflect requirements related to consumer finances, as well as the payment of consumer rents. All recovery plans will include a residential component.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 11

We recommended that the Director, DMH develop procedures for ensuring the establishment of burial funds from patient accounts.

DMH RESPONSE

DMH officials stated in its response that St. Elizabeth's will complete a review of patients for whom the hospital is representative payee, but no burial fund is in place. Accordingly, patients will be advised of the benefits of establishing a burial fund. Additionally, a new

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representative payee responsibilities policy and procedure has been implemented which includes specific procedures for excess balance monitoring.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

RECOMMENDATION 12

We recommended that the Director, DMH take action, as appropriate, to recoup any overpayments due the District.

DMH RESPONSE

DMH is taking action to assess the amount of overpayment due to the DC Government for clients identified in the OIG report and any other DMH clients.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

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FINDING 3: TRACKING AUDIT RECOMMENDATIONS

SYNOPSIS

The Department's system for tracking the status and monitoring the implementation of recommendations made in previous audit reports was not effective. Our review of actions taken in response to the most recent independent audit disclosed that the Department opted to collectively address 26 recommendations and did not address each recommendation separately. As a result, many of the previously reported conditions still exist. These include: (1) the failure to establish internal controls over the PAS in regard to cash management and the related reconciliation process; (2) the lack of a formal assessment and/or reevaluation to determine the continued need for a representative payee; (3) the incomplete position descriptions for social workers and mental health specialist which do not describe case manager responsibilities; and (4) the inconsistent procedures for handling cash and processing check requests among the mental health centers.

DISCUSSION

Much of the benefit from audit work is not in the findings reported or the recommendations made, but in their effective resolution. It is management's responsibility to address audit findings and implement recommendations. Management also should establish a process to track the status of the recommendations to ensure that they are effectively implemented.

The Office of the Receiver for the District of Columbia's Commission on Mental Health Services (CMHS) engaged Price Waterhouse Coopers, LLP, (PWC), an independent accounting firm, to perform a management audit.[1] The scope of work included an evaluation of the patient accounts functions within the CMHS. The report "Commission on Mental Health Services Management Audit" was issued April 13, 2000, and contained 7 findings and 25 recommendations.

As part of our audit, we evaluated actions taken by management, as well as the Department's procedures, for tracking and implementing the audit findings and recommendations contained in the PWC audit report. Our efforts were focused on the recommendations with the most significant impact on management of patient accounts. We determined that the Department did not implement the recommendations related to patient account issues discussed in the report. A brief description of the significant findings and recommendations contained in the PWC report, and our observations follow:

[1] CMHS came out of receivership in June 2001, and is now the Department of Mental Health.

FINDINGS AND RECOMMENDATIONS

1. **Finding:** There was a lack of internal controls over the PAS in regard to cash management and the related reconciliation process.

   A. **Finding Synopsis.** The PWC report observed that the PAS was reconciled to manually prepared spreadsheets maintained by an employee rather than to the monthly bank statement, and often reconciled 2½ months after the close of the month. For the period October 1, 1999, through February 29, 2000, case managers had not accounted for $24,000 in cash distributed by the Cashiers Office. Further CMHS maintained a large number of dormant accounts for patients no longer associated with CMHS.

   B. **Recommendations.** The report recommended that CMHS: (1) reconcile the Patient Accounting System to the patient account bank statement; (2) resolve missing supporting documentation for cash distributed to case managers; (3) monitor dormant accounts; and (4) perform a thorough financial audit of patient account balances.

   C. **OIG Audit Follow-up.** The recommendations were not implemented.

      (1) The Department's Patient Accounts section continues to reconcile the patient accounts to manually prepared spreadsheets (Checkbook Balance). Our follow-up review noted that a proper reconciliation (a reconciliation between the PAS and the bank statement) would have revealed the PAS does not reconcile with the patient accounts bank statement and there appears to be a discrepancy of over $30,000.

      For example, the reconciliation conducted by the patient accounts section indicated the "checkbook balance" of $3,745,067.73 as of September 30, 2001, agreed with the adjusted bank balance of $3,745,067.73. However, the PAS, the official record, indicated a balance of only $3,712,253.77, i.e., a difference of $32,813.96. Also, our review noted 6 outstanding deposits totaling $5,258 dating back 3 to 9 years prior that had not been recorded by the bank.

      (2) On February 14, 2002, we performed an unannounced review of the case managers' supporting documentation for cash advances. Case managers are advanced cash for patients on a Form 165, Authorization For Disbursement of Personal Funds of Medically Competent Patients, with the name of the patient noted on the form. After the case manager transfers the cash to the patient, the patient signs the Form 165, and the completed Form 165, coupled with the signature of a witness, is returned to the cashier's office.

      On the date of our review, for fiscal year 2001, there were 18 open authorizations for disbursement, representing 22 different transactions totaling

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$5,137, outstanding from as far back as February 26, 2001 (about a year). For fiscal year 2002, there were 102 open authorizations for disbursement, representing 156 transactions totaling $28,777, and dating back to October 5, 2001. Department procedures require that the completed Form 165's be returned to the Patients' Account Unit within 7 days.

The 120 authorizations for disbursement represent cash that has been distributed by the Patients' Account Unit to case managers. Since the case managers had not returned the completed copy of Form 165 (with patient signatures acknowledging receipt of the cash), we could not determine whether the patient had received the cash. In our opinion, disbursement of funds without evidence of a signed acknowledgement of receipt by the patient was contrary to the Department's policies and procedures for proper accounting of dispersed patient funds.

(3) The Department did not monitor dormant accounts. As noted in our report, there are about 600 dormant accounts for deceased patients that have been dormant for 20 to 30 years. As further noted in this report, there are more than 800 accounts for patients discharged for more than 180 days; some discharged as far back as 1990, or more than 10 years.

(4) Although the Receiver reported that a reconciliation process was conducted to substantiate the patient account balances, the details of that process were not made available to us. The Receiver, under court order, provided periodic reports to the court, which only partially addressed the PWC report recommendations.[2] Regarding the PWC report recommendation on conducting a thorough financial audit, the Receiver's report indicated, "still not fully reconciled though amount reduced". OIG auditors were not provided the results of the reconciliation process, but the discrepancy of over $32,000 disclosed during our audit of the September 30, 2001, bank reconciliation indicates the recommendation contained in the PWC report had not been adequately addressed and a financial audit of the patient accounts is still needed.

[2] The Receiver's report addressed the PWC audit report, but reduced the five findings on patient accounts to one line item that made tracking of the recommendations impractical.

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2. **Finding:** Management does not assess the continued need for representative payee.

   A. **Finding Synopsis.** The PWC report observed that a psychiatrist formally documents the initial need for a representative payee but there is no subsequent revaluation, and that CMHS retained the responsibility of representative payee after the patient had been discharged.

   B. **Recommendations.** The PWC report recommended that CMHS: (1) develop a formal process to revaluate the need for a representative payee; (2) appoint contract care providers as the representative payee; and (3) incorporate representative payee performance standards into provider contracts.

   C. **OIG Audit Follow-up.** The recommendations were not implemented. We found that the Department has not issued any policies or procedures addressing representative payees. As noted previously in our audit report, as of September 30, 2001, the Department is still the representative payee on over 800 patients that were discharged for over 180 days, some for more than 10 years.

3. **Finding:** Position descriptions for social workers and mental health specialist did not describe case manager responsibilities.

   A. **Finding Synopsis.** The PWC report observed that case mangers were not formally trained to administer budgeting/financial information and to limit patient access to funds for basic necessities. The report also noted only 100 of over 600 case managers attended a training session in July 1999.

   B. **Recommendations.** The report recommended that CMHS modify position descriptions to accurately reflect case manager responsibilities, train and educate all case mangers during a mandatory training session, and conduct periodic reviews to ensure case managers fulfill their financial obligations.

   C. **OIG Audit Follow-up.** The recommendations were not implemented. The Department was unable to provide any documentation to indicate that case manager position descriptions were modified, that training classes were conducted, or that periodic reviews of case managers' fiduciary responsibilities were conducted. As noted previously in our audit report, we observed ten instances where patients were not provided with spending money for personal needs.

FINDINGS AND RECOMMENDATIONS

4. **Finding:** Procedures for handling cash and processing check requests are inconsistent among the mental health centers.

   A. **Finding Synopsis.** The PWC report observed that case managers at the various mental health centers used different procedures for requesting cash. The report also noted that large sums of patient funds, requested for personal spending were not accounted for with receipts. Further, the report also stated that it appeared case managers were distributing cash for personal spending to known substance abusers.

   B. **Recommendation.** The PWC report recommended that CMHS monitor regional health centers' requests for patient funds.

   C. **OIG Audit Follow-up.** The recommendation was not implemented. Our audit found that case managers at the various mental health centers were still using different procedures for requesting cash, as evidenced by the wide disparity in the amount of cash provided to patients. For example, we reviewed patient fund requests in process as of February 14, 2002. Of 15 patient requests for funds at 1 regional health center, 12 were for $300, and averaged $270 per voucher request. For the same period, another regional health center had 31 outstanding requests for patient funds; none were for $300 and the average was less than $110 per voucher request. Our audit also identified instances where patients were not provided with funds for personal needs, instances where large cash disbursements for personal spending were not documented, and instances of large cash distributions to patients with substance abuse problems.

RECOMMENDATION 13

We recommended that the Director, DMH develop a formal tracking system that addresses individual recommendations and ensures that all recommendations contained in this, prior, and subsequent audits are implemented.

DMH RESPONSE

DMH officials provided the OIG with a matrix that addresses individual recommendations and assigns responsibility to ensure that all recommendations contained in this, prior and subsequent audits are implemented.

OIG COMMENT

The actions planned and taken by DMH should correct the conditions noted.

FINDINGS AND RECOMMENDATIONS

RECOMMENDATION 14

We recommended that the Director, DMH obtain the services of an independent public accounting firm to conduct an immediate audit of the patient accounts to reconcile account balances in the Patient Account System with bank balances.

DMH RESPONSE

DMH officials stated in its response that it has already completed this reconciliation process. In March 2002, DMH contracted with Deva & Associates (an audit firm used and recommended by the DC Office of the Chief Financial Officer) to perform the bank reconciliations. By the end of April 2002, all bank statements had been reconciled up thru March 31, 2002. DMH has identified a staff accountant who will maintain the reconciliations until the independent agency is appointed rep payee.

OIG COMMENT

The work performed by Deva & Associates reconciled the bank statements to the patient account checkbook. Our recommendation was to perform a reconciliation of the subsidiary accounts, which comprise the total account balances in the Patient Account System, to the bank balances. This will ensure that all funds are accounted for. A reconciliation of the subsidiary ledgers to the bank statement balances for the month of September 2001 identified that subsidiary balances were approximately $30,000 less than those reported on bank statements. We consider this recommendation open.

EXHIBIT A

DEPARTMENT OF MENTAL HEALTH

RESPONSE TO OFFICE OF THE INSPECTOR GENERAL'S AUDIT OF PATIENT ACCOUNTS

Exhibit A
OIG No. 01-1-06RM(a)
Final Report

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

02 MAY 31 PM 3:26

Office of the Director

May 29, 2002

Charles G. Maddox, Esq.
Inspector General
Office of the Inspector General
717 14th Street, N.W., Suite 500
Washington, D.C. 20005

Dear Mr. Maddox:

Enclosed is our final response to the recommendations of the Office of the Inspector General's (OIG) Audit of the Department of Mental Health's (DMH) Patient Accounts (OIG NO. 01-1-06RM(a)). We appreciate your time and effort. It is a tremendous contribution to this agency as it helps us with the further restructuring of the organization.

The enclosed response will show that this agency is actively engaged in corrective action. I would like to take the opportunity again to thank you for your efforts.

Sincerely,

Martha B. Knisley
Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

RESPONSE TO OFFICE OF THE INSPECTOR GENERAL'S AUDIT OF PATIENT ACCOUNTS

INTRODUCTION

In August 2001, the newly appointed Director of the new Department of Mental Health (DMH) requested the Office of the Inspector General (OIG) to conduct an audit of Patients Accounts as part of the overall audit of the new Department. The Director had determined that immediate and thorough attention needed to be given to Patients Accounts as the new Department established priorities among the myriad of Department functions that needed serious remediation and improvement. DMH greatly appreciates the work performed by the OIG in the audit of Patient Accounts.

The new Director requested this specific audit for three reasons

First, DMH has a fiduciary and moral obligation to consumers who are committed to or otherwise served by DMH and for whom DMH has some responsibility to assure that consumer incomes are protected and entitlements are made available in a timely and appropriate manner. Many adult mental health consumers with a serious mental illness are either unable to work or cannot sustain employment over an extended period of time and have only meager entitlements as their sole source of income. The amount each consumer receives monthly is barely enough for the consumer to secure shelter, food, transportation and incidentals as they fight their way through recovery from the devastating disease of mental illness. Many persons require assistance and/or the services of a "payee" to assure the funds they receive are available for these life-sustaining needs. It is the highest priority of this new Department to assure the health and safety of consumers along with assuring their basic needs are met.

Second, the parties in *Dixon v. Williams* had requested PriceWaterhouseCoopers (PWC) conduct a management audit of the Commission on Mental Health Services in 2000. A wide range of deficiencies related to the patients' accounts management functions were major findings of that review. It was the view of the new Director of DMH as she assumed her new responsibilities in May 2001 that the Receiver's office had not given adequate attention to the section of the PWC audit on Patient Accounts and that a second review by the OIG would help validate and update those findings to assist DMH as it began corrective actions in the area of Patient Accounts. Director Knisley also felt that the OIG would be a vital resource to the new Department as the Director was building a new management team as required in the Mental Health Establishment Act of 2001. It was her opinion that the new team would be challenged with a tremendous set of new and remedial tasks.

Third, the Director had begun planning for not only remediating problems with Patient Accounts but shifting the responsibility of Representative Payee from DMH to an independent third party and setting new policies and requirements for contract providers and residential providers so that a more accountable, non-conflictual system could be established.

The Director had sought out the services of [redacted], an expert in client benefits. [redacted] had overseen reform of the Representative Payee process in Ohio a number of years ago. The reforms adopted there have been adopted in many states and have been promoted by the Social Security Administration across the country. [redacted] only began in December of 2001 and began immediately to assist DMH. He was engaged fulltime for a period of three months and remains available on a consultative basis. Thus, DMH set up a Representative Payee Workgroup in December 2001 under the direction of [redacted]. The workgroup met and began implementation of corrective actions in December 2001 to address the significant deficiencies in the current Patient Accounts Management System. It was hoped that the OIG findings could inform and/or validate the efforts being taken by DMH to reform Patient Accounts. Since the work of the workgroup is still very much a work in progress, these findings will be reviewed carefully and integrated into DMH's overall corrective action plan. We are pleased to see that this report validates the work already in progress and that the OIG was also able to uncover additional areas for remedial action.

This report has three major sections. The first section describes the current status of DMH practices related to patient funds management. The second section details a fundamental restructuring of the Patient Accounts Management System (PAMS) that was begun in December 2001. The third section lists each of the OIG report's recommendations followed by the DMH response and a status of the implementation of each response.

DMH CURRENT STATUS

Review of policies and procedures. In September 2001, the management of St. Elizabeths and the Community Services Agency (CSA)[1] began a complete review of all policies and procedures to assure policies and procedures would be consistent with and would promote the requirements of the Mental Health Establishment Act of 2001 and the Court Ordered Plan in the matter of *Dixon v. Williams*. Prior to this review, both agencies used a single set of policies promulgated by the former Commission on Mental Health Services. Given the high volume of policies involved and the amount of change occurring in the system, this review is ongoing and is intended to identify those policies that are adequate and those that need additional revision. Policies related to patient funds are included in this review.

Review of deceased patients' accounts. In October 2001, St. Elizabeths began reviewing the accounts of all deceased patients. The purpose of the review was to address

[1] The Community Services Agency is the community outpatient services agency operated by the Department of Mental Health.

a concern raised in the PriceWaterhouseCoopers report that funds of deceased patients were being maintained in the Patient Accounts System. This concern was verified by the OIG report and DMH is continuing to identify those accounts and attempt to contact relatives of the deceased patients.

Status of discharged patients' funds. In November 2001, the new DMH Mental Health Rehabilitation Services Certification Standards became rules in the DC Municipal Regulations (Title 22, DCMR Chapter 34, final ruling effective 11/9/01). This, along with the restructuring of DMH, began the process of separating the CSA from St. Elizabeths. Previously, St. Elizabeths did not "discharge" patients to the CSA as the term "discharge" is normally understood. Rather, patients were "outplaced" to the CSA. The result of outplacement was a lack of accountability for how discharged patients' funds were handled. This lack of accountability was confirmed by the findings in the OIG report. In April 2002, the CSA became certified as a Core Services Agency under the new DMH Mental Health Rehabilitation Services Certification Standards. This certification even further splits the CSA apart from St. Elizabeths. The result is that the CSA now admits and discharges its patients just as any other community health center does. As a Core Service Agency, the CSA is now independently responsible for locating discharged consumers and ensuring that funds are returned to the appropriate party and has a process in place for doing that. This process was developed beginning in December 2001 by the Representative Payee Workgroup and is explained in more detail in the response to OIG Recommendation #4. At the time of discharge, the Hospital Associate Director for Finance and Information Systems coordinates identification of those accounts that need to be closed with the Patient Accounts Unit at DMH.

Minimum balance accounts. With the September 2001 separation between the DMH Authority, St. Elizabeths, and the CSA, separate policies and procedures were developed for inpatients versus community-based consumers. St. Elizabeths now has a minimum balance policy for inpatients.

However, for community-based consumers served by the CSA and other contract providers, establishing minimum balance criteria is not a useful monitoring tool. Many consumers require all of their monthly income to meet their basic needs. Therefore, their accounts will always have very low balances. The Representative Payee Workgroup determined in December 2001 that a more useful criterion would be to monitor accounts with no activity for a certain period of time. This process was begun in January 2001 and is explained in more detail in the response to OIG Recommendation #6.

Internal controls for supporting documentation. Documenting expenditures of representative payees' has been a cumbersome process. Prior the CSA's certification as an MHRS provider, there was a general lack of involvement in consumers' financial affairs and lack of training of case managers in rep payee duties and responsibilities. Now the CSA is required to have a financial management component in every consumer treatment plan, with particular emphasis on those consumers who require rep payee. The goals in the financial management component identify the extent to which consumers need training and assistance in managing their funds. For example, when a consumer has

shown that complete access to large sums of money resulted in behavior that damages their well being, access to funds is addressed in the individual recovery plan. The community support team member is responsible for ensuring that the funds are spent in accordance with SSI guidelines, ensuring minimum personal needs are met, and documenting how the SSI funds are spent.

St. Elizabeths Hospital is implementing enhanced procedures to correct mistakes and ensure that the documentation is obtained for all funds given to inpatients. That procedure is listed in more detail in the response to OIG Recommendation #7. The procedures include provisions for additional verification of receipts for expenditures. The position descriptions for social workers are being amended to reflect the new requirements of the procedure.

In the past, the DMH Division of Fiscal and Administrative Services did quarterly audits of case managers' compliance with documentation requirements. DMH has decided to increase the audits to a monthly basis.

Evaluating the need for a rep payee. In December 2001, the Representative Payee Workgroup determined that too many current rep payee consumers were functioning at a level at which they did not need a rep payee. For inpatients at St. Elizabeths, a process exists to evaluate whether or not a patient needed a rep payee. During completion of the recovery plan, a patient's ability to handle funds is assessed. During the assessment process the need for the consumer to have a rep payee is evaluated using the Social Security Administration's Form SSA-787, which is used by Social Security to determine whether a consumer will require a representative payee. The physician on the team completes the form and the form is used by the treatment team to evaluate the consumer's ability to manage his/her own funds. If a patient is determined to be incapable of handling funds (as determined in accordance with SSA guidelines), the social worker on the unit coordinates requests for establishment of a representative payee on behalf of the patient.

At the CSA, the goals in the financial management component of the recovery plan identify the extent to which consumers need training and assistance in managing their funds. Recovery plans are required to be updated at least every 90 days. During the update process the need for the consumer to have a rep payee is evaluated using the same process as the Hospital. Social Security Administration's Form SSA-787, is completed and used by the treatment team to evaluate the consumer's ability to manage his/her own funds. The Representative Payee Workgroup developed special guidance for physicians and other treatment team members to use in completing Form SSA-787. Training of CSA staff began in April 2002 and will be completed by the end of June 2002.

Notification of change in address. In the past, there was a great deal of fragmentation of the former system in regard to notification of case managers and other parties about all aspects of a consumer's status, including changes in residence and commitments. Case managers lacked training regarding rep payee duties and responsibilities. Formerly, St. Elizabeths Hospital had a Benefits Assistance Unit that was charged with managing all consumers' benefits, including SSI and SSDI. The interface between this unit and the

case managers never worked effectively. In December 2001, the CSA section of the Benefits Unit was dissolved and responsibility for consumers' benefits became the responsibility of the case managers. As recommended by the Representative Payee Workgroup in December 2001, mandatory case manager training for Social Security Disability Income regulations occurred in March 2002. Mandatory training for case managers in Rep Payee regulations is currently being coordinated by the CSA Training Office.

One of the goals of implementation of the Mental Health Rehabilitation Standards is to provide the financial incentive to agencies to have more contact with their consumers. The result of this increased contact will be a greater awareness of consumers' residence and commitment status. In addition, DMH (through its contract management information system) and the CSA (through an information system to be procured this year) will be automating the process of tracking consumer care. This will provide increased and more-timely communication of changes in consumers' status. Concerning commitments, in March 2002, the CSA and St. Elizabeths began a daily staff meeting to review the previous days' commitments to the inpatient units at St Es. These meetings provide immediate feedback of changes to consumers' commitment status, which case managers use to notify Social Security of such changes.

For inpatients at St. Elizabeths, a process for notifying Social Security already exists. At time of transfer/discharge from the Hospital, the Patient Financial Services office is contacted via hard copy placement letters, court order, 90-day letter packages, and/or other documentation to assure appropriate paperwork is submitted to patient funding source. This process is also used to assure that address changes (from hospital to community) are reported to Social Security.

Payment of rents. As a result of the Representative Payee Workgroup, DMH determined that its rent payment process was not adequate. Currently, responsibility for initiating the process to have a consumer's rent paid monthly lies with the case manager. The system (which is being changed) only allows for paying rent in one large process, which was driven by the fact that most consumers receive benefits checks at the beginning of the month.

In December 2001, the Representative Payee Workgroup recommended that a two-cycle rent payment system be established. Under the new process, consumers who have adequate funding in their accounts on the 15th of the previous month will have their rent checks issued by the 1st of the following month. All other rent checks will be issued by the 10th of the month. Implementing this process required specialized programming of the Patient Accounts software. The DMH Division of Fiscal and Administrative Services will establish procedures to improve and monitor the rent payment process.

Also, at the recommendation of the Representative Payee Workgroup in December 2001, the CSA began the process of amending all relevant job descriptions to include requirements related to the management of consumer finances, as well as the payment of consumer rents. This process will be completed by June 1, 2002. In addition, the CSA's

new MHRS recovery plan includes a residential component that will require documenting the establishment of the monthly rent payment.

Loss of benefits and burial funds. One responsibility of a representative payee is to ensure that funds are provided for a consumer's needs and that large balances do not accumulate and cause the consumer to lose benefits. St. Elizabeths and the CSA have policies and procedures in place to reduce the risk that individuals lose benefits.

For inpatients at St. Elizabeths, social workers are responsible for monitoring patient finances and advising the treatment team when funds are available and/or need to be spent. The Patient Accounts Unit is now distributing individual listings of account balances on a regular basis, that are sent to social workers for review prior to filing. A review is completed of patients for whom the hospital is representative payee, but no burial fund is in place. Treatment teams discuss with the patient the advisability of establishing such a fund. Requirements established by the Social Security Administration for representative payees will be followed in all cases.

In February 2002, at the recommendation of the Representative Payee Workgroup, the CSA developed an immediate corrective action plan to resolve this serious issue by implementing the Representative Payee responsibilities policy and procedures for monitoring rep payee accounts. Under this procedure the case manager is notified when a consumer's SSI funds exceed $1,900. This alerts the case manager to the potential excess funds and allows the case manager time to ensure that funds are spent in accordance with Social Security regulations. Establishing a burial fund is an important component to keeping a consumer's funds from exceeding $2,000. The relevant procedure is detailed in the response to OIG Recommendation #11.

As part of the rep payee duties and responsibilities mandatory training, case managers will be trained to counsel consumers to use their SSI funds to establish a burial fund. In addition, the establishment of a burial fund will be included in the financial management component of the recovery plan. Social Security requires that the consumer consent to the establishment of a burial fund.

This corrective action plan should significantly reduce the risk of consumers losing their SSI and SSDI benefits. However, in order to deal with the immediate challenges of consumers at risk of losing their benefits, the CSA CFO currently receives the balance detail report daily and provides immediate feedback to program directors about their consumers' situations. This situation will be corrected by June 1, 2002.

DMH is committed to monitoring and enforcing existing and future policies and procedures related to patient funds. A formal process has been developed that will ensure compliance with applicable Federal and DC laws and regulations. That process is explained in more detail in the response to OIG Recommendation #13.

FUNDAMENTAL RESTRUCTURING OF THE PATIENT ACCOUNTS MANAGEMENT SYSTEM

As noted in the previous section, DMH has identified deficiencies in the Patient Accounts Management System. While these deficiencies are being addressed, DMH believes that more needs to be done and has initiated a comprehensive restructuring of this function. Many of the current problems are related to the administration of the patient accounts for outpatient consumers served by the CSA, which is administered by DMH. The basic problem is that the PAMS is essentially an ***inpatient***, institutional system that has been adapted over the years to serve the ***community-based*** consumers served by the CSA. Adapting this inpatient system to meet the more complex, and time critical needs of community clients never resulted in an efficient or effective program.

In responding to the very apparent deficiencies in the program, DMH management decided the best approach would be to establish a separate, community-based program to perform the Representative Payee and Patient Accounts function for CSA clients. DMH also wanted to avoid the conflict of interest that exists if the Representative Payee is a provider of mental health clinical or housing services, a concern noted by an earlier Consumer Accounts Task Force Report. Accordingly, this function will not be established within DMH or reassigned to contracted housing providers. Rather, DMH has issued an RFP to solicit one or more well established community service organizations, whose primary mission is <u>not</u> the delivery of mental health services, to provide the Representative Payee and Patients Accounts function for community-based clients served by the CSA.

Listed below is the current timeline for vendor selection, purchase and implementation of the new system:

[redacted] was engaged in December 2001 to consult on the reforms in the Representative Payee functions. This included analysis of the problems, negotiations for changes with the Social Security Administration, assistance to the Representative Payee workgroup and in staff training, for recommendations on patients accounts and to write the RFP for the independent Representative Payee function.

[redacted] completed status report to Director Knisley.

- RFP draft completed in February 2002.
- RFP issued on April 1, 2002. DMH has budgeted $450,000 for this contract.
- Pre-proposal conference on April 22, 2002. Lorna Walters, Acting Division Director, Social Security Administration attended as well as individuals from DMH Office of Contracting and Procurement, Patient Accounts, and Organizational Development. Two community organizations, Bread for the City and Marshall Heights Community Center also attended.
- Proposals due by May 15, 2002.
  Contract award by July 31, 2002.
- Implementation completed by October 1, 2002 (beginning of FY 2003).

It should also be noted that [redacted] assisted the DMH in establishing an "expedited benefits process. St. Elizabeths, the CSA staff and contract agency have already been trained to begin this process immediately.

In addition to the requirements established by the Social Security Administration for organization Representative Payees, DMH has established additional requirements and performance expectations in the RFP in response to concerns regarding client access to funds and financial and program accountability that are inherent in the audit findings as set out below. Those requirements and performance expectations are listed below:

> The Contractor must provide a copy of its current bonding agreement with an insurance company or mortgage holder that guarantees payment for unforeseen financial loss through the dishonest actions of a corporate officer or employee of the Contractor.
>
> The Contractor must agree to implement procedures to receive input from DMH funded and certified providers who are providing mental health services to Representative Payee clients. The purpose of such procedures will be to incorporate any provisions of the mental health Individualized Recovery Plan related to use of client financial resources into the client's monthly Representative Payee budget. The Contractor shall also work closely with the mental health provider agency to work with each Representative Payee client on personal money management skills so that clients may become their own payee at the earliest possible time (Note: The contract between DMH and the selected organization will include provisions that do not penalize the Contractor financially for reducing the number of Representative Payee clients it serves.)
>
> The Contractor's hours of operation must be during normal business hours, Monday through Friday of each week, holidays excepted.
>
> The Contractor shall hold the Representative Payee client's funds in an interest bearing checking or savings account with a properly authorized financial institution in a manner that minimizes servicing charges to the Representative Payee account and maximizes funds available to the Representative Payee client.
>
> The Contractor shall maintain an internal accounting system that meets all of SSA's requirements and which also includes flags to alert the Contractor to circumstances where the client's account is under the amount necessary to meet the client's support needs or is over the amount which threatens loss of benefits; and any other instances of unusual account activity. The contractor shall send notice to the consumer and consumer's clinical manager of balance alert so that consumer and clinical team may explore appropriate corrective actions.
>
> The Contractor shall provide monthly financial reports to the Department of Mental Health.
>
> The Contractor shall provide information to each consumer referred, explaining representative payee ship responsibility and the consumer's right to establish with Social Security who will be his or her representative payee. The Contractor shall establish a monthly budget for each Representative Payee client at intake. The format for the monthly budget shall be prescribed by DMH. Changes to the budget shall be made as the client's circumstances change. All checks and cash

disbursements shall be made in accordance with the dates and times specified in the monthly budget. Routine cash/check disbursements must be available to the client at least once each week. Further, the Contractor shall make provisions for additional requests for monies outside the established budget up to three instances a month within the client's available balance. Any appropriate additional requests for money must be available to the client the following business day. The Contractor shall also make provisions for emergency disbursement of client funds related to critical housing or medical needs.

The Contractor shall ensure that not less than $70 (or current rate) per month is available for personal needs for the Representative Payee client.

- The Contractor must provide directly to each Representative Payee client an account expenditure and balance statement at least once each month. Upon request, an account expenditure and balance statement will also be sent to the clinical team manager responsible for the consumer's monthly budget. Further, the contractor shall provide an account balance statement immediately upon request by the Representative Payee client during normal business hours.

  The Contractor shall assume full responsibility for any penalties for late payments and under no circumstance pay for such penalties from Representative Payee monies. Federal regulations prohibit a representative Payee from passing on the cash of the representative payee's mistakes to the client.

  The Contractor must receive training from the Social Security Administration and participate in a pre-implementation review prior to becoming Representative Payee for any clients.

  The Contractor must provide a sixty (60) day notice to the client before notifying SSA if the Contractor seeks to terminate the Representative Payeeship for the client. The Contractor must transfer all account history to any successor Representative Payee.
- The Contractor shall agree that the Contract may be terminated immediately if DMH receives and verifies documented evidence of substantial noncompliance with the requirements of this RFP (i.e., the identity of a client or information about a client is disclosed without proper written authorization) or any illegal activity with respect to Representative Payee funds. The contract between DMH and the contractor shall specify more precisely the nature of such occurrences.

  Under no circumstances may the Contractor charge a client for Representative Payee services.

DMH believes that these requirements will effectively reduce the risk of the reoccurrence of issues that DMH asked the OIG to address in their review of Patient Accounts.

Since the new contracted Representative Payee program for CSA clients will not be operational until October 2002 and DMH will continue to operate the Representative Payee function for St. Elizabeths inpatients, corrective actions have been implemented that either address the OIG reports findings or the findings of earlier reviews. DMH believes it is important to note that many corrective actions had been implemented beginning in December 2001. However, in light of the OIG findings, those corrective actions are listed as responses to each of the OIG report recommendations.

RESPONSES TO OIG RECOMMENDATIONS

OIG Recommendation #1: DMH should strengthen policies and implement procedures, in accordance with D.C. probate laws and regulations, for handling accounts of deceased patients.

Response. As noted earlier in this report, St. Elizabeths and the CSA are rewriting internal policies to address a more expedient way to release funds following a patient's death. A review of D.C. Probate regulations and a legal opinion from General Counsel is needed prior to finalizing our policy.

Status. *Expected date of completion: May 15, 2002.*

OIG Recommendation #2: DMH should review all files of deceased patients, initiate actions to ensure relatives of deceased patients are notified of funds that remain in their accounts and disburse the funds in accordance with probate or other legal requirements.

Response. The Associate Director for Finance and Information Systems of St. Elizabeths and the Chief Financial Officer of the CSA will continue to coordinate the review with the DMH Patient Accounts Unit to identify all deceased patients' funds. Funds will continue to be disbursed in accordance with probate and other legal requirements.

Status. *Expected date of completion: May 15, 2002.*

OIG Recommendation #3: DMH should develop and implement procedures to ensure discharged patients are provided funds at the time of discharge.

Response. As part of the ongoing policy review, St. Elizabeths is developing policies that allow inpatients to withdraw all funds at time of discharge if they are medically competent. Procedures coordinating Office of Patient Financial and Legal Affairs (OPFLA) with other financial systems are being developed. The policies and procedures address different needs of competent and incompetent patients and allow all medically competent patients to receive the entire amount in their account on the day of discharge. In cases where the St. Elizabeths is the representative payee for incompetent patients, procedures will coordinate the transfer of funds with the OPFLA prior to the patient's discharge.

Status. *Expected date of completion: May 15, 2002.*

OIG Recommendation #4: Locate discharged patients and disburse funds to identified discharged individuals.

Response. The Associate Director for Finance and Information Systems at St. Elizabeths will continue to coordinate identification of those accounts that need to be closed with the Patient Accounts Unit at DMH. Staff at the Hospital will complete Form 267 on all discharged patients for whom an address can be found. Accounts for patients who cannot be located will be referred back to the Finance Department for processing in accordance with Federal and DC regulations regarding unclaimed funds.

Status. *Expected date of completion is May 15, 2002.*

Response. The CSA Finance Department will use the monthly Patient Account Services (PAS) account balance report to identify all discharged consumers for whom funds are maintained in the PAS bank account.
Status. *Expected date of completion: May 8, 2002.*

Response. Case managers will attempt to contact all discharged consumers and determine where the funds should be sent. Form 267 will be completed for every discharged consumer and submitted to PAS for processing of the disbursement.
Status. *Expected date of completion: May 15, 2000.*

Response. Consumers who cannot be located will be referred back to the Finance Department for processing in accordance with Federal and DC regulations regarding unclaimed funds.
Status. *Expected date of completion: May 21, 2000.*

Response. Ongoing monitoring of discharged consumers' funds will occur on a quarterly basis using the PAS report procedure above

Status. *Expected date of completion: Ongoing*

OIG Recommendation #5: DMH should direct community residential facilities to establish patient accounts for all of the Department patients residing in their facilities. Transfer representative payee responsibilities to contractor operated community residential facilities, where appropriate.

Response. DMH will meet the intent of this recommendation by making the independent agency chosen by the RFP process the representative payee for all community-based consumers. It has been and will continue to be the policy of DMH to discourage the use of community residential facilities because of the inherent conflict of interest associated with being a provider of service to a consumer while at the same time being responsible for the management of that consumer's funds.

OIG Recommendation #6: DMH should establish policies and implement procedures for maintaining accounts with minimum balances and eliminate those accounts that do not meet those criteria.

Response. St. Elizabeths has established a policy that requires a minimum account balance of $25.00 and closes accounts that fall below that amount for more than 90 days. Social workers monitor the accounts using the monthly Patient Accounts System reports.

However, for community-based consumers served by the CSA and other contract providers, establishing minimum balance criteria is not a useful monitoring tool. Many consumers require all of their monthly income to meet their basic needs. Therefore, their accounts will always have very low balances. The Representative Payee Workgroup determined in December 2001 that a more useful criterion would be to monitor accounts with no activity for a certain period of time. This process was begun in January 2001 and is delineated in the CSA's Representative Payee Responsibilities policy and procedure. Those procedures are as follows:

At the end of each quarter, Patient Account Services generates a report showing the activity in each consumer account for that quarter.

2. Accounts with no activity during that quarter are flagged and the CSA CFO makes a request to that consumer's case manager to determine why there is no activity on the account.
3. The case manager attempts to contact the consumer to see if they still want DMH to maintain the account.
4. DMH continues to maintain accounts for consumers who so request.
5. If, after repeated attempts, the case manager cannot contact the consumer, the funds are processed in accordance with Federal and District regulations.

Status. *Planning began in December 2001. Implementation began in April 2002. There will be ongoing quarterly monitoring of dormant accounts.*

OIG Recommendation #7: DMH should establish internal controls and procedures to ensure that supporting documentation is obtained for all funds disbursed to patients and that all disbursements are authorized for bona fide daily-living expenses.

Response. As noted in the RFP requirements, the independent rep payee agency will be required to have an established set of internal controls and procedures that meet all SSA requirements. St. Elizabeths Hospital is implementing the following enhanced procedures to correct mistakes and ensure that the documentation is obtained for all funds given to inpatients:

Social workers have the responsibility to complete the form that goes to the Patient Account Unit.

- The social worker's signature is verified, and the client's account reviewed to determine availability of funds as well as amount.

- The document is processed and forwarded to the Cashier's Office for disbursement to the social worker.
  Social workers sign for all cash at time of disbursement; however, if the inpatient is also able to sign for the money he/she will also sign for cash received. If the social worker is not available, the nurse on the unit witnesses the receipt.
- A copy of this form is returned within two working days to the Cashier's Office for filing.

Social workers position descriptions are being amended to clarify these requirements.

Status *This entire procedure will be monitored on a monthly basis beginning May 15, 2002.*

Response. CSA case managers have been trained in the treatment planning model that will require a financial management component for each consumer. The independent agency that will become rep payee will have internal controls that all case managers will be required to follow. Training for case managers in rep payee duties and responsibilities has been planned.

Status. *Expected dates of completion: Rep payee duties and responsibilities mandatory training – June 15, 2002; Effective April 2002, all new CSAs are required to have new treatment plans. Process started in March 2002, must be completed by June 30, 2002.*

Response. In the past DMH has had a member of the Office of Fiscal and Administrative Services conduct quarterly audits of the adequacy of individual case manager's documentation of how consumer's funds were spent. DMH will devote the resources to implement a monthly audit process for the period of time until the independent agency is appointed rep payee.

Status. *Monthly audits to begin in May 2002.*

OIG Recommendation #8: DMH should develop and implement a formalized process to evaluate and reevaluate the need for a consumer to be assigned a representative payee.

Response. For inpatients at St. Elizabeths, the process of evaluating a patient's need for a rep payee during treatment planning will continue as explained on page 3 of this report.

Status. *Ongoing.*

Response. CSA treatment teams have begun the process of incorporating a financial management component in every treatment plan. This process is explained in detail on page 3 of this report. During the update process, the CSA will utilize SSA Form SSA-787 to evaluate the continued need for a rep payee.

Status. *Expected date of completion: Effective April 2002, all new CSAs are required to have new treatment plans. Process started in March 2002, must be completed by June 30, 2002.*

OIG Recommendation #9: DMH should develop procedures for ensuring beneficiary entitlements are reduced when changes of addresses occur, to meet Social Security Administration guidelines for dispensing minimum payments to consumers, and ensuring changes of address are reported to the Social Security Administration where release from a hospital, imprisonment, or commitment by court order because of mental impairment occurs.

Response. St. Elizabeths will continue to follow its existing procedure of notifying Social Security when a patient is admitted and discharged.

Status. *Ongoing*

Response. The CSA has completed Social Security Disability Income training for all case managers. Training in rep payee duties and responsibilities has been planned. The CSA will coordinate the installation of its management information system to interface with the DMH contract management system.

Status. *Expected dates of completion: Rep payee duties and responsibilities mandatory training – June 15, 2002; Social Security Disability Income mandatory training – Completed March 2002; Implementation of CSA management information system – October 1, 2002.*

OIG Recommendation #10: DMH should develop procedures to ensure that consumer accounts are charged rent and that District funds are not used to pay for this expense until responsibility for a patient account transfers to the Community Residential Facility.

Explanation. A two-cycle rent payment system will be established. Job descriptions will be amended to reflect requirements related to consumer finances, as well as the payment of consumer rents. All recovery plans will include a residential component.

Status. *Expected dates of completion: Implementation of the two-cycle rent process – May 15, 2002; Amendment of job descriptions – May 15, 2002; Implementation of recovery plan residential component – June 30, 2002.*

OIG Recommendation #11: DMH should develop procedures for ensuring the establishment of burial funds from patient accounts.

Response. As explained in detail on page 4 of this report, St. Elizabeths will complete a review of patients for whom the hospital is representative payee, but no burial fund is in place. Patients will be advised of the benefits of establishing a burial fund.

Status. *Implementation of this process will be completed by May 15, 2002.*

Response. A new Representative Payee Responsibilities policy and procedure has been implemented. It includes the following procedures for excess balance monitoring –

On the 1st and 15th of each month, the Patient Accounts Unit generates a report that details the balances in each consumer's account. The report is due to the CSA CFO by the 5th and 20th, respectively.
Using that report, the CSA CFO (or designee) identifies the balances in excess of $1,900 and prepares a report for tracking purposes. This enables the case manager to avoid exceeding the $2,000 maximum.

3 The report is handed out to CSA program managers at their bi-weekly meeting with CSA management.

4 Case managers are responsible for preparing a corrective action plan for each client with a balance in excess of $1,900. The plan determines what the money will be spent on and requires completion dates.

5 The corrective action plans are submitted to the CSA CFO for approval. Inadequate reports are returned to the case manager for correction.

6 If the plan is not corrected immediately, disciplinary action is taken against the case manager and supervisor.

In order to address this serious problem immediately, the Chief Financial Officer of the CSA has implemented a process of daily monitoring of account balances to ensure that all CSA consumers will not be in a position of losing their benefits.

Status. *Expected dates of completion: Implementation of Representative Payee Responsibilities policy and procedure – Begun February 2002, ongoing monitoring; Daily excess balance monitoring – already in process, completed by June 1, 2002.*

OIG Recommendation #12: DMH should take action, as appropriate, to recoup any overpayments due the District.

Response. DMH is taking action to assess the amount of overpayment due to the DC Government for clients identified in the OIG report and any other DMH clients.

Status. *Expected date of completion: July 1, 2002.*

OIG Recommendation #13: DMH should develop a formal tracking system that addresses individual recommendations and ensures that all recommendations contained in this, prior and subsequent audits are implemented.

Response. DMH developed a matrix that addressed individual recommendations and a copy was provided to OIG auditors.

OIG Recommendation #14: DMH should obtain the services of an independent public accounting firm to conduct an immediate audit of patient accounts to reconcile balances in the Patient Account System with bank balance.

Response. DMH has already completed this reconciliation process. In March 2002, DMH contracted with Deva & Associates (an audit firm used and recommended by the DC Office of the Chief Financial Officer) to perform the bank reconciliations. By the end of April 2002, all bank statements had been reconciled up thru March 31, 2002. DMH has identified a staff accountant who will maintain the reconciliations until the independent agency is appointed rep payee.

Status. *Completed April 2002.*